### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2012 FORM APPROVED OMB NO. 0938-0391

	K MEDICARE & MEDIC						IB NO. 0938-0391			
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI				
		15G696	B. WIN	B. WING			/2012			
		_		STREET A	ADDRESS, CITY, STATE, ZIP CODE					
NAME OF	PROVIDER OR SUPPLIEF	R		336 W 56TH ST						
ARC OF	NORTHWEST IND	IANA INC, THE			LLVILLE, IN 46410					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			COMPLETION			
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE			
W0000										
			W0	000						
	This visit was fo	or an extended								
	recertification as	nd state licensure survey.								
		ina source incompane suit vey.								
	Datas of surroy	October 0 10 11 12								
	1	October 9, 10, 11, 12								
	and 19, 2012									
	Facility number:	. 002102								
	-									
	Provider number									
	AIM number: 2	00317190								
	Surveyor Chris	stine Colon, Medical								
	Surveyor III/QM									
	Surveyor III/QIV	IKI								
	The following fe	ederal deficiencies also								
	_	lings in accordance with								
	460 IAC 9.									
		mpleted 10/30/12 by Ruth								
	Shackelford, Medic	-								
	Shackehold, Wiedle	Lai Surveyor III.								
	1		1				1			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUI	TIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	00	COMPL	ETED
		15G696	B. WING			10/19/	2012
NAME OF F	AD CHARLED OR CHARLIED		<del>'</del>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>		336 W 5	56TH ST		
	NORTHWEST INDI			MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL	P.	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
W0125	The facility must of clients. Therefore and encourage in their rights as clie citizens of the Un right to file comple process.  Based on observinterview for 3 of (clients #1, #2 art to ensure the clie obtaining a legal maker to assist in decisions.  Findings include  1. A review of conducted at the office on 10/10/11 #1's record indice emancipated adult medical record in Notation dated 4 Service Coordinated DNR (Do Not Rethem [client #1] won't accept that alzheimers."	client #1's record was facility's administrative 12 at 2:35 P.M Client ated she was an llt. Review of client #1's	W012	25	The guardianship process has been started for 2 out of the 3 clients needing guardians. The third client remains in the hosp and family is determining whet they want to take guardianship Service Coordinator will continut to seek alternate guardianship until guardians are secured for each client. (11/28/12)  To ensure future compliance, Service Coordinator will monitor the guardianship process for completion.	ne ital her ue	11/28/2012

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Event ID: 8LFT11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		(X2) MU A. BUIL B. WING	DING	NSTRUCTION  00	(X3) DATE COMPL 10/19/	ETED	
	PROVIDER OR SUPPLIER			336 W 5	ADDRESS, CITY, STATE, ZIP CODE 56TH ST LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the PIC line has issue since its the antibiotics into [  Notation dated 4 staff called the Shas been moved Unit) because shand needed intuly scope her lungs to open any block.  Notation Dated 5 [client #1]. She a few days but her Notation dated 5 #1]. Kidneys has She's on dialysis permanently."  Notation dated 5 [client #1]. Rem stated she's unlike trach (tracheotor	/22/12: "Group home C stating that [client #1] to ICU (Intensive Care e coded during the night bationDoctor wants to in the morning in hopes kage that may be there."  5/2/12: "SC visited had been off the vent for ad to be put back on."					
	staff called SC a hospital she was	/14/12: "Group home nd stated that while at the informed that the n trying to reach the					

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Event ID: 8LFT11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		LDING	NSTRUCTION 00	(X3) DATE COMPI 10/19		
	PROVIDER OR SUPPLIER		336 W 5	DDRESS, CITY, STATE, ZIP CODE 66TH ST LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE	(X5) COMPLETION DATE
	family regarding Unable to reach	the trach situation. family."				
	phone call from that the hospital contacting client for a trach, whic as possible), or h	/14/12: "Received a [Doctor name], he stated has been unsuccessful in 's relatives for a consent h is needed asap (As soon the feels she will worsen as SC notified, nurse also				
	still unable to rea and no return cal messages left. H	Iospital is considering courts to have guardian				
	discharged from	/18/12: "[Client #1] was [Hospital name]She dialysis 3 days a week."				
	assessment performance homeNon-verborninimal sign land 1-2 cm (centime	/27/12: "Nursing ormed at client's oal, communicates with aguageApproximately ter), 0 depth open area, will obtain order				
	phone call from	0/1/12: "I received a group home, DSP (Direct onal) on 9/29/12, stated				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G696	B. WIN	IG		10/19/	2012
NAME OF F	PROVIDER OR SUPPLIER	3	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					56TH ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRII	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		rent to [Dialysis Center					
	_	alysis treatment. Staff					
		accessing her dialysis					
	_	sh substance excreted					
	from the dialysis	s catheter port."					
	NT. (. () 1 1 1 1 1	0/2/12: !!					
		0/2/12: "Consumer					
		although admitted due to					
	-	a staph infection in her					
	blood and a UTI	` •					
	<i>'</i>	sumer is on two IV					
	(Intravenous) an	tibiotics."					
	The Conference	Summary dated 7/1/12					
		Is assistance in making					
	1 -	ons." The Developmental					
		ed 7/1/12 indicated:					
		oney. She shops with					
		vision. Needs assistance					
	in banking and b						
		Support Plan (ISP) dated					
	7/15/12 indicate						
	Diagnosis: Seizu						
	. –	ypothyroidism, Hearing					
	_	mments: Receives anti					
		ons monitored by					
	neurologistHyp	-					
		vere arthritis, unsteady					
		ERD (Gastro-Esophageal					
	· ·	at risk for heartburn and					
		GI (Gastro Intestinal)					
	bleeding, periph						
	-	relling of legs, skin					
	breakdown due t	to dermatitisWill					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696			LDING	NSTRUCTION  00	(X3) DATE COMPL 10/19/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	336 W 5	DDRESS, CITY, STATE, ZIP CODE 6TH ST LVILLE, IN 46410	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR gesture informat			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	medicationwill to said like coins likenessWill let to her address an numberWill conew sign language and communication later and learning to ident medicationThe Assessment was (Inter Disciplina annual meeting. agreed that she in Hypothyroidism Fall High Risk Pareakdown relater increased incontarthritis." Further record failed to it immediate familiactively involved 2. A morning of at the group hom A.M. until 8:05 and observation clier holding her head	arn to trace and or point d telephone ontinue to learn/identify 4 ge words and to recognize e with her book."  Imm Meeting" dated d: "[Client #1] is ealth and safety skills by ify where she takes her e General Risk Factors completed by the IDT ry Team) during this The IDT determined and leeds a Seizure, and Hypertension, and lan, risk for further skin ed to dermatitis and linence, GERD, pain from er review of client #1's indicate she had any y members that were					
	looked off and the	nen began holding her					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G696	B. WIN	G		10/19/	2012
	PROVIDER OR SUPPLIER			336 W 5	DDRESS, CITY, STATE, ZIP CODE 56TH ST LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	head with no res	ponse.					
	conducted at the office on 10/10/1/#2's record indic emancipated adule. Review of client indicated:  Notation dated 4 taken by staff to (Emergency Rocunsteady on her walking. DX (D)  Notation dated 5 incident report the stating the [clien and without asking and fell hitting heye has 3 inch be and nose has a subridge. Ice pack Notation dated 6 problemsUnab ambulateunable Notation dated 6 the group home, been a noted characteristics.	nt #2's record was facility's administrative 12 at 3:10 P.M Client ated she was an alt.  /18/12: "[Client #2] was [Hospital name] ER om) because she was very feet and having difficulty biagnosis) ear infection."  /22/12: "Received an anis afternoon from staff at #2] got up in the night, ang for staff assistance are left eye and nose. Left ruise above the eyebrow mall red area on the applied."  //26/12: "Gait alle to stand or a to staff stated there has ange in condition, gait					
ı	unsteady, occasi	onal confused					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696			LDING	NSTRUCTION  00	(X3) DATE COMPI 10/19			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  336 W 56TH ST  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
		6/28/12: "Patient was antin toxicity."						
	consumer. Cons	for F/U (follow up) on numer doing well, 5.5 (normal range is 10 to						
	[Hospital name]. Dilantin level wa Nose and Throat	/2/12: "F/U call to Consumer doing well as 19.8. A ENT (Ear c) consult requested due to g a sinus infection."						
	[Hospital name]. procedure of Let	/15/12: "F/U call to Consumer is having It Debridement Mastoid morningDilantin level						
	discharged on 7/	/10/12: "[Client #2] was 9/12. She had a decrease ose and four new						
	that consumer is is not doing anyt also is wetting a	/20/12: "Staff reported getting worst (sic). She hing for herself. Stated and stooling on herself, ag or feeding herself."						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G696	B. WIN	IG		10/19/2012
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	56TH ST	
ARC OF	NORTHWEST IND	IANA INC, THE		MERRII	LVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)	DATE
		7/17/12: "I was informed				
		staff that consumer was				
		r. She is now having a lot				
		rious areas of her body.				
		ing her head all of the				
	time."					
	The Conference	Summary dated 5/26/10				
	indicated: "Cont	•				
	assistance in ma					
	decisions."	king major me				
		ntal Assessment dated				
		d: "All of her banking				
		rocedures must be done				
		She cannot be sent on				
		s. She does no shopping.				
		bear to understand time				
		valents. She does not				
	_	ate time on the clock with				
	various actions of					
		Support Plan (ISP) dated				
	4/25/12 indicated					
		are Disorder, Profound				
	_	omments: Has seizure				
		on and medications				
	· ·	urologistProfound				
	_	loss, has constant ear				
	_	edication dailyReceives				
		tions for various physical				
	-	RD-receives medication,				
		ed skin breakdownWill				
		Dilantin and information				
	about itWill co					
		inue to relearn to write				
		mue to releasi to write				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE COMPL 10/19/	ETED	
	PROVIDER OR SUPPLIER		S. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE S6TH ST LVILLE, IN 46410	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	BE	(X5) COMPLETION DATE
	will make a purc client #2's record	hase." Further review of latest failed to indicate she attended to the family members that volved.					
	at the group hom A.M. until 8:05 A wheelchair and v	eservation was conducted the on 10/9/12 from 5:50 A.M Client #3 sat in a when asked questions out other subjects not testions.					
	conducted at the office on 10/10/1/#3's record indic emancipated adu Summary dated "Needs assistanc decisions." The Developmen 12/20/11 indicate money. Cannot	nt #3's record was facility's administrative 2 at 3:40 P.M Client ated she was an lt. The Conference 12/20/11 indicated: e in making major life ntal Assessment dated ed: "Does not use be sent on independent s. Shops with close					
	supervision. She all banking/budg assistance in tell understand time Does not associa various actions a name the days of	e requires assistance with eting needs. Needs ing time and does not intervals or equivalents. te time on a clock with and events. She cannot the week and refer ang and afternoon. She					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G696	B. WING		10/19/2012
NAME OF I	DROWNER OF GURBLIEF		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	X	336 W	56TH ST	
ARC OF	NORTHWEST IND	IANA INC, THE	MERRI	LLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		een day of the week,			
	minute-hour, mo	onth-year."			
	The ISP dated 4	/19/12 Indicated:			
	Diagnosis: Psyc	chotic Disorder			
	Unspecified, Bij	polar DisorderWill (sic)			
	her money skills	s by earning to make			
	change for \$1.00	0 using various			
	coinsWill imp	rove her (number) skills			
	_	ddressWill improve her			
		by relearning to print her			
		rove her health and safety			
		the purpose of clozapine."			
		of client #3's record failed			
		ad any immediate family			
		ere actively involved.			
	members that w	cic actively involved.			
	An interview wi	th the Service			
		C) was completed at the			
	· ·	strative office on			
		50 P.M The SC			
		s #1, #2 and #3 did not			
		ctioned decision makers			
		ith financial and medical			
		SC further indicated			
	, ·	nd #3 were incapable of			
		nanaging their finances			
		dependently make			
	financial and me	edical decisions.			
	9-3-2(a)				

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER:  15G696	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COM 10/1	(X3) DATE SURVEY COMPLETED 10/19/2012			
ARC OF	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE  336 W 56TH ST  MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  10/19/2012		
	PROVIDER OR SUPPLIER		B. WIN	336 W	ADDRESS, CITY, STATE, ZIP CODE	1	
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRI	LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
W0149	The facility must written policies ar mistreatment, neg Based on observinterview, the facilimplement their neglecting to profor 2 of 3 sample #2), for their documents.  Findings include  1. A morning of at the group hom A.M. until 8:05 A.D. Direct Support P walked with her chest, while stan #2 had an unstead complete assistant walking to a whom remainder of the client #2 sat in a head. Client #2 when asked quest began holding her and a sudden with the client #2 was con "All of a sudden "All of a sudden "All of a sudden "All of a sudden "Interview with the client #2 was con "All of a sudden "All of a sudden "All of a sudden "Interview with the client #2 was con "All of a sudden "All of a sudden "All of a sudden "Interview with the client #2 was con "All of a sudden "All of a sudden "Interview with the client #2 was con "All of a sudden "Interview with the client #2 was con "All of a sudden "Interview with the client #2 was con "All of a sudden "Interview with the client #2 was con "All of a sudden "Interview with the client #2 was con "All of a sudden "Interview with the client #2 was con "All of a sudden "Interview with the client #2 was con "All of a sudden "Interview with the client #2 was con "Interview with the client #2 was	ENT OF CLIENTS develop and implement and procedures that prohibit glect or abuse of the client. ation, record review and cility neglected to meglect policy by ovide adequate health care ed clients (clients #1 and cumented health care  esservation was conducted are on 10/9/12 from 5:50  A.M At 6:10 A.M., Professional #2 (DSP) arms around client #2's ding behind her. Client dy gait and needed nee from staff while eelchair. During the observation period, wheelchair holding her did not communicate and stions looked off and then er head with no response.  th DSP #2 was conducted and A.M DSP #2 stated mpletely independent and she just started not doing self." DSP #2 stated	WO	149	The Community Services Ni will assess all reported injur change in physical condition well as follow up with medic appointments per agency po (11/28/12) To ensure future compliance the Service Coordinator will monitor nur assessment of injuries and pressure sores.	es or as al blicy.	11/28/2012

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE COMPI 10/19/	ETED	
	PROVIDER OR SUPPLIER		B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE 56TH ST LVILLE, IN 46410	-1	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)  ear infection and she		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	started having fa hospitalization fo	Ils and then after her or dilantin toxicity, she d no one knows why."					
	Developmental I (BDDS) reports	Cacility's Bureau of Disability Services was conducted on P.M Review of the :					
	4/2/12Submitted #2] was leading whe walked a little missed the first so #2] fell on the bust of her nose and a assisted [client # the health and sa staff). The health (sic) ice pack to inch scratch above health tech also a cointment to the country the bridge of her applied for the belieft eye and to led does not have a fireview of the recommedical record distaff assessed her was leading to the staff as	d Date: 4/3/12: "[Client (sic) forward so much as e too quickly that she tep of the bus. [Client as step hitting the bridge above her left eyeStaff 2] up and took her to see fety tech (non nursing h and safety tech apply left eye which has an we the left eye brow. The apply (sic) antibiotic one fourth inch scratch on nose. An ice pack was reginning swelling of the seen the pain. [Client #2] all risk plan." Further ord and client #2's id not indicate nursing r injuries and did not was seen by a physician.					

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Event ID: 8LFT11

Facility ID: 003103

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	15G696	A. BUII	LDING	00	COMPLI 10/19/2	
		100090	B. WIN			10/19/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC. THE			56TH ST LLVILLE, IN 46410		
				<u> </u>			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
1110	Report dated 4/1	*		1.10			BIIIE
	1	8/12Submitted Date:					
	_	ved an incident report					
		nt #2] was walking to the					
		3/12 in the home, lost her					
		on her knees. Staff					
		r and found no redness,					
		sing from the fall at the					
	_	on 4/15/12 a small dime					
		eloped on each knee from					
		2 in which staff noticed					
		client #2] with her					
		lical treatment required					
		However, when [client					
		at the ER (Emergency					
		2 for an ear infection, the					
	·	at this caused imbalance					
	_	ed with the fall that					
	occurred. [Clien						
	_	ne dizziness associated					
	with it."						
	Report dated 5/4	/12Date of Knowledge:					
	•	ted Date: 5/15/12:					
	"Received an inc	eident report today					
		4/12 stating [client #2]					
	was unsteady on	her feet and lost her					
	-	own to the ground but was					
		who eased her down.					
		ury from the fall but					
		stain a small, 1 inch by 1					
	-	bruise on her left upper					
		(sic) thumb when they					
	caught her."	· ·					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8LFT11

Facility ID: 003103

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		(X2) MU A. BUIL B. WING	DING	NSTRUCTION  00	(X3) DATE COMPL 10/19/	ETED	
	PROVIDER OR SUPPLIER NORTHWEST INDI			336 W 5	DDRESS, CITY, STATE, ZIP CODE 56TH ST LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	5/16/12: "Receiffrom staff that an #2] attempted to restroom without assistance. She causing a red manose and a 3 incleyebrowFollow #2]'s injuries have fall risk plan was therefore is up to Report dated 6/5 ready to leave for unhooked the sea and before staff of her wheelchair into her chair and scratch on her nowere what result Report dated 6/2 Knowledge: 6/2 6/29/12: "Staff at that [client #2] hand physical stat and unable to he toiletSent [clie evaluation and tradmitted to [Hos	syed an incident report round 2:45 A.M., [client get out of bed to use the tasking for staff fell hitting her face ark on the bridge of her in bruise above her left by-Up Report: [Client ye healed. [Client #2]'s a recently created and o date."  /12: "While getting reworkshop, [client #2] at belt of her wheelchair could catch her, fell out rStaff assisted her back did a body check. A ose and a bloody nose ed from the fall."					

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Event ID: 8LFT11

Facility ID: 003103

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696			LDING	NSTRUCTION  00	(X3) DATE COMPL 10/19/	ETED	
	PROVIDER OR SUPPLIER		р. үүн	STREET A	DDRESS, CITY, STATE, ZIP CODE 56TH ST LVILLE, IN 46410	•	
(X4) ID PREFIX	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION
TAG	debridement was found to be infect was causing disticavityDilantin come downFolConsumer also Therapy evaluation treat once insuratreatmentNurse considering leng check orders as of Nursing staff will (Inter Disciplina more frequent lewe are concerned her Dilantin lever frequent checks of the IDT team.  A review of client conducted at the office on 10/10/10 of client #2's me  Notation dated 4 taken by staff to (Emergency Rocumsteady on her walking. DX (D.)  Notation dated 5 incident report the stating the [client	level continues to slowly flow-Up Report: seen for initial Physical fon on 7/19/12, plan is to nee approves sing staff presently the of Dilantin Level ordered by Doctor. Il discuss with the IDT ry Team) team about vel checks. At this time, d with the instability of els, and will request more if that's the determination		TAG	DEFICIENCI		DATE

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Event ID: 8LFT11

Facility ID: 003103

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G696		LDING		10/19/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	<b>{</b>			56TH ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		er left eye and nose. Left		TAG	DLI ICILI (CT)		DATE
	1	ruise above the eyebrow					
	*	mall red area on the					
	bridge. Ice pack						
	g	· ····································					
	Notation dated 6	5/26/12: "Gait					
	problemsUnab	le to stand or					
	ambulateunabl	e to stand."					
		5/27/12: "During a visit at					
		staff stated there has					
		inge in condition, gait					
	unsteady, occasi conversation."	onal confused					
	conversation.						
	Notation Dated 6	6/28/12: "Patient was					
	admitted for Dila						
		J					
	Notation dated 6	5/29/12: "Called					
	[Hospital name]	for F/U (follow up) on					
	consumer. Cons	sumer doing well,					
		3.5 (normal range is 10 to					
	20) at this time."	1					
	Notation data 1.7	7/2/12: "F/U call to					
		Consumer doing well					
	' ' '	as 19.8. A ENT (Ear					
		t) consult requested due to					
		g a sinus infection."					
		J <del>V</del>					
	Notation dated 7	1/15/12: "F/U call to					
	[Hospital name].	. Consumer is having					
	1 ^	ft Debridement Mastoid					
	cavity done this	morningDilantin level					

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Event ID: 8LFT11

Facility ID: 003103

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		(X2) MULTIPLE ( A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 19/2012	
	PROVIDER OR SUPPLIER		STREET	TADDRESS, CITY, STATE, ZIF 7 56TH ST RILLVILLE, IN 46410	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	discharged on 7/in her Dilantin dinedications."  Notation dated 8 that consumer is is not doing anyth also is wetting at she is not walking.  Notation dated 9 by group home is not getting better of bruising to various Also she is holding time."  Further review of indicated physic #2's Dilantin lev 1/12/12, 7/18/12 and 9/4/12 (for the record did not in dilantin orders where on the mentioned indicate what clinwere.  2. A review of contact of the record of the re	/10/12: "[Client #2] was 9/12. She had a decrease ose and four new  /20/12: "Staff reported getting worst (sic). She thing for herself. Stated and stooling on herself, ag or feeding herself."  /17/12: "I was informed traff that consumer was ar she is now having a lot rious areas of her body. In the she had all of the folient #2's record from the she had all of the folient #2's record from the she had all of the she had all of the folient #2's dicate if client #2's dicate if client #2's dicate if client #2's dicate if client #2's dicate and did not ent #2's dilantin levels				
		facility's administrative 12 at 2:35 P.M Review				

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Event ID: 8LFT11

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		LDING	NSTRUCTION  00	(X3) DATE COMPL 10/19/	ETED	
	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE 56TH ST LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) dical record indicated:	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		(X5) COMPLETION DATE
	Notation dated 6 assessment performance in Non-verber minimal sign land 1-2 cm (centime noted to buttock tomorrow." Further did not indicate assessments of the did not indicate address client #1 record did not in healed. No docu #1's record from address client #1 Notation dated 1 phone call from Support Profession that consumer we name] for her dianoted that after a catheter a greenifrom the dialysis documentation we indicate how the the physician to catheter site and and if the facility and assessed client.	/27/12: "Nursing ormed at client's oal, communicates with guageApproximately ter), 0 depth open area will obtain order ther review of the record				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8LFT11

Facility ID: 003103

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	TPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	00	COMPL	
		15G696	B. WING			10/19/	2012
NAME OF I	PROVIDER OR SUPPLIE	P.	S	TREET A	ADDRESS, CITY, STATE, ZIP CODE		
					56TH ST		
ARC OF	NORTHWEST IND	DIANA INC, THE	V	/IERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
		l although admitted due to					
	_	s a staph infection in her					
		I (Urinary Tract					
	Infection). Cor	nsumer is on two IV					
	(Intravenous) as	ntibiotics."					
	A review of the	facility's "Policy for					
	Handling Cases	s of Neglect and Abuse"					
	_	was completed at the					
		istrative office on					
	1	0 P.M., and indicated: "In					
		the general welfare of the					
	•	orthwest Indiana has in					
		wing policy with regard to					
		or exploitation of clients by					
		rohibits all abuse, neglect					
		n of our clientsStaff will					
	_						
		port any allegations of					
	_	or exploitation of our					
	clients per agen						
		glect is defined as					
		ing a client in a situation					
	-	eat to his/her health and					
	_	amples include, but are not					
	_	iving a client of food,					
	clothing, shelter	r or medical care."					
	An interview w	ith the Licensed Practical					
	Nurse (LPN) w	as conducted at the					
	facility's admin	istrative office on					
	10/12/12 at 12:	10 P.M The LPN					
	indicated staff s	should document all					
	incidents of ski	n breakdown immediately.					
		client #1 had a sore as					
	I		- 1				

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Event ID: 8LFT11

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		15G696	B. WIN			10/19/	2012
NAME OF P	ROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE		336 W 5 MERRIL	66TH ST LVILLE, IN 46410		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
	·	LPN stated "Yes, she					
		d what the status of					
		nented sore was, the LPN					
	stated "I have no						
		as no documentation to					
		's documented sore had					
		d treated. The LPN					
		1 was not seen by a					
		open wound area on her					
		sked if there were orders					
		ient #1's catheter site, the					
		n't know." When asked					
		ionitored client #1's					
	· ·	LPN stated "No." When esults of client #2's PT					
		the LPN stated "She did					
		al PT assessment due to					
		rance being inactive."					
		cumentation available for					
		e client #2's ordered PT					
		een completed to address					
		falls with injury. When					
		client #2's dilantin levels					
		be tested, the LPN stated					
		When asked what client					
	#2's dilantin leve						
		cian ordered dates, the					
	LPN stated "I have	ve no idea."					
	0.2.2()						
	9-3-2(a)						

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Event ID: 8LFT11

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  15G696	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPI				
ARC OF	PROVIDER OR SUPPLIER	ANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE  336 W 56TH ST  MERRILLVILLE, IN 46410						
ARC OF  (X4) ID  PREFIX  TAG	SUMMARY S' (EACH DEFICIEN	ANA INC, THE  TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)			HOULD BE	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8LFT11

Facility ID: 003103

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		15G696	B. WIN			10/19/	2012
NAME OF B	NOVADED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			336 W 5	56TH ST		
	NORTHWEST INDI				LLVILLE, IN 46410		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCY)		DATE
TAG W0218	A morning observed the group home of A.M. until 8:05 A. Direct Support P walked with her chest, while standard and an unstead complete assistant walking to a when asked quest began holding here.	DGRAM PLAN ve functional assessment sorimotor development. ation, record review and of 3 sampled clients had unsteady gait with a with injury and used a facility failed to have a sment that addressed all bility needs.	Wo	TAG	Client #2 attended a complete physical therapy evaluation. Recommendation is for a gait belt. Community Services Nursand Service Coordinator will ensure a gait belt is ordered at that client receives the gait bel Community Services Nurse and/or Service Coordinator will train DSPs on proper use of gabelt. (11/28/12)  To ensure future compliance, Service Coordinator and nursin staff will follow-up on all rescheduled appointments to ensure they are completed with the time allowed by state requirements.	se nd t. I ait	11/28/2012
	of client #2's med	dical record indicated:					
	Notation dated 4	/18/12: "[Client #2] was					

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Event ID: 8LFT11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		(X2) MULTIPLE CO A. BUILDING	onstruction 00	CON	TE SURVEY MPLETED 10/2012	
		100090	B. WING			19/2012
	PROVIDER OR SUPPLIER		336 W 5	ADDRESS, CITY, STATE, ZIP C 56TH ST LLVILLE, IN 46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	(Emergency Roo unsteady on her	[Hospital name] ER om) because she was very feet and having difficulty biagnosis) ear infection."				
	incident report the stating the [client and without asking and fell hitting here were has 3 inch be	in safternoon from staff at #2] got up in the night, ng for staff assistance are left eye and nose. Left ruise above the eyebrow mall red area on the applied."				
	Notation dated 6/26/12: "Gait problemsUnable to stand or ambulateunable to stand."					
	the group home,	s/27/12: "During a visit at staff stated there has ange in condition, gait onal confused				
	initial examinati Patient is depend ambulation. Fur indicate the PT a conducted/comp	17/12: "Patient seen for on (Physical Therapy). dent with transfer and ther review did not assessment had been leted. No				
	Notation dated 8	2/20/12: "Staff reported				

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Facility ID: 003103

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU A. BUIL		00	COMPI	LETED
		15G696	B. WING			10/19	/2012
NAME OF PROVID		ANA INC, THE		336 W 5	ddress, city, state, zip code 56TH ST LVILLE, IN 46410	3	_
TAG R	(EACH DEFICIENC EEGULATORY OR	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
is no also she	ot doing anyth is wetting ar is not walkin	getting worst (sic). She hing for herself. Stated ad stooling on herself, g or feeding herself."  f client #2's record failed					
	nave an assess bility needs.	ment that addressed her					
Nur faci 10/1 what asset not her The revi asset con of a and injuctie com	rse (LPN) was ility's adminis 12/12 at 12:10 at the results of the essment were, have the initimedical insurere was no dociew to indicate essment had be ducted/complate wheelchair at to address heary. The LPN	th the Licensed Practical seconducted at the strative office on P.M When asked of client #2's PT the LPN stated "She did at PT assessment due to rance being inactive." cumentation available for eclient #2's ordered PT een eted to address her use that all times for mobility or documented falls with indicated as of 10/12/12 have a PT assessment					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G696	B. WING		10/19/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	NAME OF PROVIDER OR SUPPLIER			56TH ST	
ABC OF	NODTHWEST INC	NAMA INC. THE		ILLVILLE, IN 46410	
	ARC OF NORTHWEST INDIANA INC, THE			ILLVILLE, IN 464 IO	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0318	483.460				
	HEALTH CARE				
	1	ensure that specific health			
	care services red	quirements are met.			
			W0318	Refer to tag	11/27/2012
	Based on record	I review and interview, the		33112/5/12Community Service	
	Condition of Pa	rticipation, Health Care		Nurse sees clients once a we	
		met as the facility failed		either at Day Services or at th	
				home. The nurse will make ar	
	1 1	uate nursing services for 2		assessment for all changes of	Ī
	of 3 sampled cli	ents (clients #1 and #2).		conditionor injuries within 24 hours. The Community Service	200
				Director is in charge of nursin	
	Findings includ	a.		this time. The expectation is t	•
	Findings include	<del>5</del> .		the Nurse will make regular vi	
				to both home and Day Service	
	Please refer to V	W331. The facility nursing		on a weekly basis and assess	
	services failed f	for 2 of 3 sampled clients		clients within 24 hours for any	
	(clients #1 and #	#2) by not ensuring they		changes in condition. This	
	`	g services according to		information is then given to th	e
	their medical ne			Community Services Director	,
	men medical ne	eus.		Service Director and Behavio	ral
				Health Director to ensure the	
	9-3-6(a)			team is aware of the situation	
				ensure future compliance, the	
				Nurse and Service Coordinate	
				will monitor the clients weekly	l l
				well as assessing any change	
	1		1	I injuries within twenty four hou	irs.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		15G696	B. WIN			10/19/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>		336 W 5	56TH ST	
ARC OF	NORTHWEST INDI	IANA INC, THE		MERRII	LLVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	l `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
W0331	483.460(c) NURSING SERV	ICES				
		provide clients with nursing				
		dance with their needs.				
	Based on observation, record review and		W0	331	Community Services Nurse wi	II 11/27/2012
	interview, the fa	cility nursing services			assess all changes in client	
		sampled clients (clients			condition and schedule Dr	
		ot ensuring they received			appointments as necessary. T ensure future compliance,	0
	l ' -	according to their			Service Coordinator will make	
	medical needs.	woording to their			bi-weekly visits to group home	
	incurcui necus.			monitor clients for any chang		
	Findings include		condition. 12/5/12Community			
	Findings include.				Services Nurse sees clients or	
	1 4				a week either at Day Services at the home. The nurse will ma	
	1	oservation was conducted			an assessment for all changes	
	• •	ne on 10/9/12 from 5:50			conditionor injuries within 24	
		A.M At 6:10 A.M.,			hours. The Community Service	
		Professional #2 (DSP)			Director is in charge of nursing	
		arms around client #2's			this time. The expectation is the Nurse will make regular vis	
		ding behind her. Client			to both home and Day Service	
	#2 had an unstea	dy gait and needed			on a weekly basis and assess	
	complete assista	nce from staff while			clients within 24 hours for any	
	walking to a whe	eelchair. During the			changes in condition. This	
	remainder of the	observation period,			information is then given to the Community Services Director,	;
	client #2 sat in a	wheelchair holding her			Service Director and Behavior	al
	head. Client #2	did not communicate and			Health Director to ensure the	
	when asked ques	stions looked off and then			team is aware of the situation.	То
	_	er head with no response.			ensure future compliance, the	
		1			Nurse and Service Coordinato	
	An interview with DSP #2 was conducted on 10/9/12 at 7:00 A.M DSP #2 stated				will monitor the clients weekly well as assessing any change:	
					injuries within twenty four hour	
		mpletely independent and			, , , , ,	
		she just started not doing				
		self." DSP #2 stated				
ı						
		ear infection and she				
	started having fa	lls and then after her			1	l

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Event ID: 8LFT11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G696	B. WIN	G		10/19/	2012
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			336 W 5	56TH ST		
	NORTHWEST IND	·		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
	_	or dilantin toxicity, she					
	just regressed an	d no one knows why."					
	A review of the	facility's Bureau of					
		Disability Services					
	_	was conducted on					
		P.M Review of the					
	reports indicated						
	Toports maicated	·•					
	Report dated 4/2	/12Date of Knowledge:					
	_	ed Date: 4/3/12: "[Client					
		(sic) forward so much as					
		le too quickly that she					
		step of the bus. [Client					
		us step hitting the bridge					
	_	above her left eyeStaff					
		[2] up and took her to see					
	_	afety tech (non nursing					
		h and safety tech apply					
	· /	left eye which has an					
		ve the left eye brow. The					
		apply (sic) antibiotic					
		one fourth inch scratch on					
		nose. An ice pack was					
		eginning swelling of the					
		essen the pain. [Client #2]					
	_	fall risk plan." Further					
		cord and client #2's					
		lid not indicate nursing					
		r injuries and did not					
	maicate chent #2	2 was seen by a physician.					
	Report dated 4/1	3/12Date of					
		8/12Submitted Date:					
	I		1				

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Event ID: 8LFT11

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
ANDILAN	OI CORRECTION	15G696		LDING	00	10/19/	
		100000	B. WIN			10/13/	∠U 1∠
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC. THE			56TH ST LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	4/23/12: "Recei	ved an incident report					
		nt #2] was walking to the					
		3/12 in the home, lost her					
		on her knees. Staff					
	checked her over	r and found no redness,					
	swelling or bruis	ing from the fall at the					
	~	on 4/15/12 a small dime					
	sized bruise deve	eloped on each knee from					
	the fall on 4/13/1	2 in which staff noticed					
	when assisting [c	client #2] with her					
	T -	lical treatment required					
	for the bruises. 1	However, when [client					
	#2] was treated a	at the ER (Emergency					
		2 for an ear infection, the					
	hospital stated th	at this caused imbalance					
	and was associat	ed with the fall that					
	occurred. [Clien	at #2] was given					
	medication for th	ne dizziness associated					
	with it." Further	review of the report did					
	not indicate the r	nursing staff assessed					
	client #2 after the	e reported fall on					
	4/13/12.						
	Report dated 5/4	/12Date of Knowledge:					
	5/15/12Submit	ted Date: 5/15/12:					
	"Received an inc	eident report today					
	5/15/12 dated 5/4	4/12 stating [client #2]					
	was unsteady on	her feet and lost her					
	balance going do	own to the ground but was					
	caught by staff w	who eased her down.					
	There was no inj	ury from the fall but					
	[client #2] did su	stain a small, 1 inch by 1					
	inch light purple	bruise on her left upper					
	arm from staffs (	(sic) thumb when they					
	I .						

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Event ID: 8LFT11

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL 10/19/	
		15G696	B. WIN			10/19/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
4DC OF	NODTHWEST IND	IANIA INIC. THE			56TH ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	_	ther review of the report					
		nursing staff assessed					
	client #2' docum	ented unsteady gait.					
	Report dated 5/1	5/12Date of					
	_	5/12Submitted Date:					
	5/16/12: "Recei	ved an incident report					
	from staff that ar	ound 2:45 A.M., [client					
	#2] attempted to	get out of bed to use the					
	restroom withou	t asking for staff					
	assistance. She	fell hitting her face					
	causing a red ma	ark on the bridge of her					
	nose and a 3 incl	n bruise above her left					
	evebrowFollow	v-Up Report: [Client					
	_	ve healed. [Client #2]'s					
		s recently created and					
	•	date." Further review of					
	•	I failed to indicate a fall					
	risk plan.	ranea to maleate a ran					
	risk plan.						
	Donort dated 6/5	/12: "While getting					
	•	• •					
		r workshop, [client #2]					
		at belt of her wheelchair					
		could catch her, fell out					
		rStaff assisted her back					
		d did a body check. A					
		ose and a bloody nose					
		ed from the fall."					
		f the report failed to					
	indicate a nursin	g assessment was					
	completed.						
	Report dated 6/2	8/12Date of					
	Knowledge: 6/2	8/12Submitted Date:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696				LDING	NSTRUCTION  00	(X3) DATE COMPL 10/19/	ETED
	PROVIDER OR SUPPLIER		B. WIN	336 W 5		<u> </u>	
	NORTHWEST INDI	·		WERKIL	LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFREENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
1710		at day service reported		1110			DITTE
		ad a change in mental					
		us. She was disoriented					
		lp herself to eat or					
		nt #2] to the ER for					
	_	reatment. She was					
		pital name] for Dilantin					
	_	-Up Report: On 7/5/12 a					
	_	s done on a tooth that was					
	found to be infec	eted. The infected tooth					
	was causing dist	ress to her sinus					
	cavityDilantin	level continues to slowly					
	come downFol	low-Up Report:					
	Consumer also	seen for initial Physical					
	Therapy evaluati	ion on 7/19/12, plan is to					
	treat once insura	nce approves					
	treatmentNurs	ing staff presently					
	considering leng	th of Dilantin Level					
	check orders as o	ordered by Doctor.					
	Nursing staff wil	ll discuss with the IDT					
	(Inter Disciplina	ry Team) team about					
	more frequent le	vel checks. At this time,					
	we are concerned	d with the instability of					
	her Dilantin leve	els, and will request more					
	•	if that's the determination					
		" Further review did not					
		T met and addressed					
	client #2's chang	e in status.					
		nt #2's record was					
		facility's administrative					
		12 at 3:10 P.M Review					
	of client #2's me	dical record indicated:					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE ( COMPL		
		15G696	A. BUI B. WIN	LDING		10/19/	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIER			336 W 5	56TH ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		/18/12: "[Client #2] was		mo	·		DATE
		[Hospital name] ER					
		om) because she was very					
	unsteady on her	feet and having difficulty					
	walking. DX (D	riagnosis) ear infection."					
		/22/12: "Received an					
	*	nis afternoon from staff t #2] got up in the night,					
		ng for staff assistance					
		er left eye and nose. Left					
	_	ruise above the eyebrow					
	_	mall red area on the					
	bridge. Ice pack	applied."					
	Notation dated 6						
	problemsUnab						
	ambulateunabl	e to stand."					
	Notation dated 6	/27/12: "During a visit at					
		staff stated there has					
		nge in condition, gait					
	unsteady, occasi	-					
	conversation."						
		C/0.0/4.0					
		6/28/12: "Patient was					
	admitted for Dila	anun toxicity."					
	Notation dated 6	/29/12: "Called					
		for F/U (follow up) on					
		umer doing well,					
		5.5 (normal range is 10 to					
	20) at this time."						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G696	A. BUI B. WIN	LDING G		10/19/	2012
NAME OF I	PROVIDER OR SUPPLIER		P. (11)		ADDRESS, CITY, STATE, ZIP CODE		
					56TH ST		
	NORTHWEST IND			<u> </u>	LVILLE, IN 46410		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Notation dated 7	/2/12: "F/U call to					
		Consumer doing well					
		as 19.8. A ENT (Ear					
		c) consult requested due to					
	consumer having	g a sinus infection."					
	Notation dated 7	7/15/12: "F/U call to					
		Consumer is having					
		ft Debridement Mastoid					
	cavity done this	morningDilantin level					
	is 15.4."						
		/10/12: "[Client #2] was					
	_	9/12. She had a decrease ose and four new					
	medications."	ose and four new					
	incurcations.						
	Notation dated 8	/20/12: "Staff reported					
		getting worst (sic). She					
	is not doing anyt	thing for herself. Stated					
		nd stooling on herself,					
	she is not walkin	ng or feeding herself."					
	Notation data 10	/17/12: "I was informed					
		staff that consumer was					
	J C 1	r she is now having a lot					
		rious areas of her body.					
	_	ing her head all of the					
	time."						
		f client #2's record					
		ian orders to have client					
		els checked were written					
	on 11/18/11, 1/1	2/12, 7/18/12, 7/25/12,					

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NAME OF PROVIDER OR SUPPLIER  ARC OF NORTHWEST INDIANA INC, THE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  7/31/12, 8/9/12 and 9/4/12 (for three weeks). Client #2's record did not indicate if client #2's dilantin orders were completed as ordered on the mentioned dates and did not indicate what client #2's dilantin levels were.  2. A review of client #1's record was conducted at the facility's administrative office on 10/10/12 at 2:35 P.M Review of client #1's medical record indicated:  Notation dated 6/27/12: "Nursing assessment performed at client's homeNon-verbal, communicates with minimal sign languageApproximately 1-2 cm (centimeter), 0 depth open area noted to buttock, will obtain order tomorrow." Further review of the record did not indicate further nursing assessments of the mentioned wound and did not indicate an order was obtained to address client #1's wound. The medical record from 6/27/12 until 10/19/12 to address client #1's documented wound.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		LDING	NSTRUCTION  00	(X3) DATE COMPI 10/19	LETED	
PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION)  7/31/12, 8/9/12 and 9/4/12 (for three weeks). Client #2's record did not indicate if the mentioned dates and did not indicate what client #2's dilantin levels were.  2. A review of client #1's record was conducted at the facility's administrative office on 10/10/12 at 2:35 P.M Review of client #1's medical record indicated:  Notation dated 6/27/12: "Nursing assessment performed at client's homeNon-verbal, communicates with minimal sign languageApproximately 1-2 cm (centimeter), 0 depth open area noted to buttock, will obtain order tomorrow." Further review of the record did not indicate further nursing assessments of the mentioned wound and did not indicate an order was obtained to address client #1's wound. The medical record find not indicate if the wound had healed. No documentation was in client #1's record from 6/27/12 until 10/19/12 to				STREET A	66TH ST	<u> </u>	
weeks). Client #2's record did not indicate if client #2's dilantin orders were completed as ordered on the mentioned dates and did not indicate what client #2's dilantin levels were.  2. A review of client #1's record was conducted at the facility's administrative office on 10/10/12 at 2:35 P.M Review of client #1's medical record indicated:  Notation dated 6/27/12: "Nursing assessment performed at client's homeNon-verbal, communicates with minimal sign languageApproximately 1-2 cm (centimeter), 0 depth open area noted to buttock, will obtain order tomorrow." Further review of the record did not indicate further nursing assessments of the mentioned wound and did not indicate an order was obtained to address client #1's wound. The medical record did not indicate if the wound had healed. No documentation was in client #1's record from 6/27/12 until 10/19/12 to	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E	COMPLETION
Notation dated 10/1/12: "I received a phone call from group home, DSP (Direct Support Professional) on 9/29/12, stated that consumer went to [Dialysis Center name] for her dialysis treatment. Staff noted that after accessing her dialysis	IAU	7/31/12, 8/9/12 a weeks). Client # indicate if client completed as ord dates and did no dilantin levels w  2. A review of conducted at the office on 10/10/1 of client #1's me  Notation dated 6 assessment performance with the consumer with the con	and 9/4/12 (for three 42's record did not 42's dilantin orders were dered on the mentioned at indicate what client #2's ere.  Alient #1's record was facility's administrative 12 at 2:35 P.M Review dical record indicated:  Approximately for the record further nursing from the review of the record further nursing from the mentioned wound and fan order was obtained to 1's wound. The medical dicate if the wound had furner the wound had for the review of the record further nursing from the mentioned wound and fan order was obtained to 1's wound. The medical dicate if the wound had furner the wound had for the wound had	IAU			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G696	B. WIN	G		10/19/2	2012
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					56TH ST		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		sh substance excreted					
	1	s catheter port." No					
		vas in the record to					
	indicate how the nursing staff was						
		hysician to monitor client					
		and did not indicate					
		facility nursing staff					
		ssessed client #1's					
	catheter site.						
	Notation dated 1	0/2/12: "Consumer					
		although admitted due to					
	_	a staph infection in her					
	blood and a UTI	-					
	· · · · · · · · · · · · · · · · · · ·	sumer is on two IV					
	(Intravenous) an	tibiotics."					
	An interview wi	th the Licensed Practical					
		s conducted at the					
	facility's adminis						
	1	0 P.M The LPN					
		nould document all					
		breakdown immediately.					
		lient #1 had a sore as					
		LPN stated "Yes, she					
	·	ed what the status of					
		nented sore was, the LPN					
		idea." The LPN					
		was no documentation to					
		l's documented sore had					
		id treated. The LPN					
		#1 was not seen by a					
		r open wound area on her sked if there were orders					
	j bullock, when a	sked if there were orders					

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Event ID: 8LFT11

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
		15G696	A. BUII B. WIN	LDING		10/19/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			336 W 5	56TH ST		
ARC OF	NORTHWEST INDI	ANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ient #1's catheter site, the		TAG			DATE
		n't know." When asked					
	if nursing staff monitored client #1's						
	_	LPN stated "No." When					
	· ·	esults of client #2's PT					
	assessment were	, the LPN stated "She did					
	not have the initi	al PT assessment due to					
	her medical insu	rance being inactive."					
	There was no do	cumentation available for					
	review to indicat	e client #2's ordered PT					
		been completed to address					
		falls with injury. When					
		client #2's dilantin levels					
		be tested, the LPN stated					
		When asked what client					
	#2's dilantin leve						
		cian ordered dates, the					
	LPN stated "I ha	ve no idea."					
	An interview wit	th the group home nurse					
	was conducted o	n 10/12/12 at 12:10 P.M					
	The nurse indica	ted there was no					
	documentation a	vailable for review to					
	indicate the nurs	ing staff requested orders					
	for client #2's Di	lantin to be tested					
	regularly. When	asked if the facility					
	nursing staff asso	essed client #2 after each					
		ed falls, she stated "No."					
	When asked if cl	ient #2 had the PT					
	_	oleted as ordered, she					
	· ·	use at the time there were					
	•	er insurance." When					
	asked if the facil						
	monitored and as	ssessed client #1's PIC					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION II	DENTIFICATION NUMBER: 15G696		LDING	00	COMPL 10/19/	ETED		
	PROVIDER OR SUPPLIER	NA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE  336 W 56TH ST  MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  CONTROL OF THE SECTION OF THE S		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
	"No." When asked documentation avaindicate all staff wand #2 were trained needs, she indicated asked if there was available for reviews taff monitored and client #1's document answered "No." Now submitted for reviews the submi	ailable for review to orking with clients #1 ad on their medical ed there was not. When any documentation we to indicate nursing d changed dressing of ented wound, the nurse to documentation was ew to indicate the taff provided nursing s #1 and #2's							

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Event ID: 8LFT11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		15G696				10/19/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
10005		ANA 1110 THE			56TH ST		
ARC OF I	NORTHWEST INDI	ANA INC, THE		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0369	483.460(k)(2)						
	DRUG ADMINIST	FRATION					
	The system for dr	rug administration must					
		ugs, including those that					
	are self-administe	ered, are administered					
	without error.						
	Based on observation, record review and W0.		369	The Community Service Nurse	;	11/28/2012	
	interview, the fac	cility failed for 2 of 17			will re-train DSP's on how to		
	medications adm	inistered to 2 of 3 clients			follow medication orders and		
	observed during				record results on Medication		
	_				Administration Record in		
	•	elients #4 and #5) to			accordance with physician's		
	administer medic	cations as ordered			order. (11/28/12) To ensure future compliance the Community Services Nurse will visit group		
	without error.						
					home at least bi-monthly for th	ree	
	Findings include	•			months and at least quarterly		
					thereafter. 12/5/12The		
	1 4				Community Service Nurse will		
	•	oservation was conducted			re-train DSP's on how to follow		
	• .	ne on 10/9/12 from 5:50			medication orders and record		
	A.M. until 8:05	A.M At 7:20 A.M.,			results on Medication		
	client #4 receive	d her morning prescribed			Administration Record in		
	medications. Dir	rect Support Professional			accordance with physician's		
		stered her "Aspirin 81			order. The Nurse will view two		
		pain) chew tablet1			medication passes per month		
		-			ensure that the Dr's medication	1	
	3	e a daychew tablet			orders are followed. This is different because this training		
	before swallowing	ngTake with			focused more on the need for		
	food/meal." Clie	ent #4 swallowed her			meal time consideration when		
	medication. Clie	ent #4 was not prompted			giving medications. The syster	m	
		not chew her medication			failed in that the staff failed to		
					give consideration to medication	ons	
	and did not take her medication with food/meal. Client #4 ate her breakfast at				requiring food or to be given or	n	
		iii #4 ate ner breaktast at			an empty stomach. To ensure		
	8:00 A.M				future compliance, the		
					Community Services Nurse an	ıd	
	2. At 7:25 A.M.	, client #5 received her			Service Coordinator will visit		
		ped medications. DSP #2			group home at least twice		
		"Ziprasidone 60 mg			monthly for three months and	at	
	aummistered her	Ziprasidone od ing			least twice monthly thereafter.		

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Event ID: 8LFT11

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	OF CORRECTION  OF CORRECTION  15G696	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMI	E SURVEY PLETED 9/2012
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	336 W 5	ADDRESS, CITY, STATE, ZIP C 56TH ST LLVILLE, IN 46410	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	capsule (antipsychotic)1 capsule orally twice dailyTake with meals. Client #5 did not take her medication with food/meal. Client #5 ate breakfast at 8:00 A.M				
	A review of "Nursing Spectrum Drug Handbook" dated 2010 was conducted on 10/9/12 at 8:00 P.M Review of the handbook indicated: "AspirinGive with food. Ziprasidone HydrochlorideTherapeutic class: AntipsychoticAdministration: Give with food."				
	An interview with the nurse was conducted on 10/12/12 at 12:10 P.M The nurse indicated staff should administer all medications as prescribed. The nurse further indicated staff should follow directions on medication labels on medication packets.				
	9-3-6(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETED	
		15G696	A. BUILDING B. WING 10/19/2012			10/19/2012	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				56TH ST		
ARC OF	NORTHWEST INDI	IANA INC, THE			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
W0388	483.460(m)(1)(i) DRUG LABELING	3 s and biologicals must be					
	based on currently accepted professional principles and practices.						
	Based on observation, record review, and		W0	388	Community Services Nurse wi	II 11/28/2012	
	interview, the fac	cility failed for 1 of 3			re-train DSP's on keeping		
	clients observed	during morning			medications in the labeled box and getting new labels for all	es	
	medication admi	nistration (client #3) to			missing or damaged labels. St	aff	
	have the medicat	tion labeled from the			will be re-trained to keep		
	pharmacy.				medication in labeled containe	r	
	F			when the method of dispens		ion	
	Findings include	·			is not conducive to labeling.		
	i mamga marada	•			(11/28/12) To ensure future compliance, Community Service	200	
	Δ morning obser	vation was conducted at			Nurse and/or Service Coordinate		
	_	on 10/9/12 from 5:50			will check medication storage		
	• •	A.M Client #3's			labeling at least bi-monthly for		
					three months and at least		
		e administered by Direct			quarterly thereafter.		
		onal (DSP) #2 at 7:36			12/5/12Community Services Nurse will re-train DSP's on		
	A.M A bottle of	•			keeping medications in the		
	. • /	haler was taken from			labeled boxes and getting new	,	
	client #3's clear p	plastic medication bin.			labels for all missing or damag		
	The bottle did no	ot contain client #3's			labels. Staff will be re-trained t	0	
	name or instructi	ions for administration.			keep medication in labeled		
	The inhaler was	not in packaging with a			container when the method of dispensation is not conducive	to	
	label. The bottle	did not contain a			labeling. If a box with a label is		
	pharmacy label.				not available, Nurse will secure		
		ninistration Record			label from the pharmacy. To		
					ensure future compliance,		
	(MAR) dated 10/1/12 to 10/31/12 was conducted on 10/9/12 at 7:40 A.M. and indicated: "Proair 90 mcg Inhaler2 puffs daily."				Community Services Nurse		
					and/or Service Coordinator will check medication storage and		
					labeling at least weekly for three		
					months and at least quarterly	-	
	<b>.</b>				thereafter.		
		th the Licensed Practical					
	Nurse (LPN) wa	s conducted on 10/12/12					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15G696		A. BUILDING  B. WING			COMPLETED 10/19/2012		
	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC		STREET ADDRESS, CITY, STATE, ZIP CODE  336 W 56TH ST  MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST B REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	at 12:10 P.M The LPN medications should have on them. 9-3-6(a)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G696	B. WING			10/19/	2012
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			336 W 5	56TH ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			LVILLE, IN 46410		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
PREFIX TAG W0436	A morning observation perion not wear prescrib	UIPMENT furnish, maintain in good clients to use and to make about the use of dentures, ing and other aids, braces, and other by the interdisciplinary by the client. ation, record review, and cility failed to provide of 3 sampled clients 3) who required  Example of the control of the contro	W04	TAG		t om or e of	11/28/2012
	was conducted o P.M. until 3:00 F	n 10/12/12 from 2:00 P.M During the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G696	B. WIN	G		10/19/2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	KOVIDEK OK SUITELEN			336 W 5	56TH ST	
	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410	_
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	BEIGHNOT	DATE
	1	od clients #2 and #3 did				
	not wear prescril	bed eyeglasses.				
	An interview with day program staff #1					
		In 10/12/12 at 2:45 P.M				
		ff #1 indicated client #3's				
		been missing for over 2 has never seen client #2				
	wear eyeglasses.					
	Client #2's recor	d was reviewed on				
		P.M A review of client				
		sion exam indicated the				
		ribed eyeglasses to wear				
	_	nearsightedness) and				
		ontrolled movement of				
		d 5/25/12 indicated:				
	1 - 1	d." Her most current				
		rly" dated 7/11/12				
	indicated "Glass	•				
	indicated Glass	es checked.				
	Client #3's recor	d was reviewed on				
		P.M A review of client				
		sion exam indicated the				
		ribed eyeglasses. The				
		ort Plan (ISP) dated				
		d: "Wears eyeglasses.				
		ed/replaced as needed.				
	These are repaire	ou/repraced as needed.				
	An interview wi	th the group home				
		al Nurse (LPN) was				
		/12/12 at 12:10 P.M				
		clients #2 and #3's				
		"probably sent out for				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G696	(X2) MULTIPLE CC  A. BUILDING  B. WING	00					
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE  336 W 56TH ST  MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE			
	repair."								
	9-3-7(a)								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		15G696	B. WIN			10/19/	2012
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				56TH ST		
ARC OF	NORTHWEST INDI	ANA INC, THE			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W9999							
	State Findings  The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:		W99	999	Service Coordinator and/or Community Services Nurse wi report incidents to BDDS within 24 hour period after receiving notification of reportable incidents will be reported to	n a ent.	11/28/2012
	460 IAC 9-3-1(b	))		the administrator immediatel upon notification. (11/28/12) ensure future compliance Se			
	following circum by telephone no business day foll summaries as recommendate as the business day following the summaries as recommendate as the business day following the business day	not met as evidenced by:  ation, record review and cility failed to report skin calls with injury involving lients (clients #1 and #2)			Coordinator and/or Community Services Nurse will report all BDDS worthy incidents within twenty-four hours of notificatio incident.		
	conducted at the office on 10/9/12 of the facility's E include any incide	facility's records was facility's administrative 2 at 12:00 P.M Review BDDS reports failed to dents of skin break down ents at this group home.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/19/	ETED	
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE 66TH ST LVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE	
	Further review o indicated:	f the BDDS reports					
	4/23/12: "Receive stating that [client bathroom on 4/1 balance and fell checked her over swelling or bruist timeHowever of sized bruise dever the fall on 4/13/1 when assisting [client showerNo meet for the bruises. If the spital stated at the land was associated occurred. [Client states of the states occurred. [Client states occurred. [Client states occurred. [Client states occurred.]	8/12Submitted Date: ved an incident report int #2] was walking to the 3/12 in the home, lost her on her knees. Staff r and found no redness, sing from the fall at the on 4/15/12 a small dime eloped on each knee from 12 in which staff noticed client #2] with her dical treatment required However, when [client at the ER (Emergency 12 for an ear infection, the nat this caused imbalance ed with the fall that					
	conducted at the office on 10/10/1	nt #1's record was facility's administrative 12 at 2:35 P.M Review dical record indicated:					
	assessment perfo	/27/12: "Nursing ormed at client's oal, communicates with guageApproximately					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		(X2) MU A. BUIL B. WING	DING	NSTRUCTION  00	(X3) DATE COMPI 10/19	ETED	
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODI 66TH ST LVILLE, IN 46410	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	noted to buttock, tomorrow." Furt	er), 0 depth open area will obtain order her review did not d wound was reported to					
	Disabilities Servi policy effective I conducted on 10 policy indicated: Bureau of Qualit (BQIS) to utilize and management tool in ensuring the individuals readministered by reported to BQIS occurrence chara uncertainty result potential to result injury to an individual to: Any breakdown relater regardless of the	Bureau of Developmental ices (BDDS) reporting March 1, 2011 was /11/12 at 5:00 P.M The "It is the policy of the y Improvement Services an incident reporting system as an integral the health and welfare of eceiving services BDDSIncidents to be include any event or cterized by risk or ting in or having the trin significant harm or ridual including but not occurrence of skin ed to a decubitus ulcer, severityA fall resulting tess of the severity of the					
	on 10/12/12 at 12 indicated incider should be reported BDDS. The LPN	th LPN #1 was conducted 2:10 P.M LPN #1 ats of skin breakdown and within 24 hours to by further indicated client a not reported timely to					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/11/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G696		A. BUILDING B. WING		COMP	COMPLETED 10/19/2012	
NAME OF PROVIDER OR SUPPLIER  ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE  336 W 56TH ST  MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	BDDS.					
	9-3-1(b)					

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